Rhode Island Department of Health

Primary Care Physician Advisory Committee

(PCPAC)

Report of the

PCPAC Mental Health Workgroup

June, 2002

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EXECUTIVE SUMMARY

Purpose:

To address Rhode Island's behavioral health crisis, the PCPAC Mental Health Workgroup, comprised of PCPAC members and others with expertise in the behavioral health field was formed. Guided by a facilitator, the Workgroup convened six times between March 21, 2001 and April 10, 2002 to discuss key issues related to behavioral health infrastructure, access, and financing and to develop recommendations that could enhance the delivery of these essential health services in Rhode Island.

Charge:

The Workgroup was charged with responding to the following focus question: *In an effort to ensure more timely, appropriate service to all patients (adults and children) who need behavioral health treatment, how can provider-to-provider communication be improved?*

Process:

Addressing a series of process questions posed by the facilitator to guide interactive analysis and planning, the agenda for each meeting focused sequentially on the following: 1) Scope of the Problem; 2) Barriers; 3) Practical Vision; and 4) Recommendations.

Scope of the Problem:

Rhode Island is facing a crisis in the delivery of behavioral health services. There is a critical shortage of providers, particularly child psychiatrists. Extrapolating from national data, between 25,000 - 50,000 Rhode Islanders need some behavioral health intervention annually.[1] The already severe shortage of psychiatrists was exacerbated by the recent closure of outpatient services at Butler Hospital, the state's only private, nonprofit adult, adolescent and child psychiatric and substance abuse hospital. Nationally and in Rhode Island, primary care physicians provide a substantial proportion of the behavioral health interventions.[2] Data indicate that up to 90% of psychotropic medications are prescribed in the primary care setting.[3] In addition, difficulty accessing behavioral health services and communication barriers are commonly cited problems when referral to a behavioral health specialist is needed.

[1] Into the Millenium --> Recovery (RI Mental Health Plan, June, 1999)
[2] National pharmacy data
[3] Rhode Island pharmacy data

Barriers:

A number of major barriers were identified including: 1) patient needs surpass current provider capacity; 2) inadequate reimbursement rates impact the recruitment of behavioral health specialists, particularly child psychiatrists; 3) the state's changing population demographics necessitate continued cultural competence training and access to linguistically appropriate providers and translation services; 4) communication gaps between providers complicate medication management; and 5) current referral mechanisms are poorly coordinated and administratively inefficient.

Practical Vision for Improved Communication:

The Workgroup's vision of ideal communication between primary care and behavioral health providers is grounded in the belief that consultation with the appropriate behavioral health specialist should function in a manner similar to any other specialist referral. It was envisioned that once the need for a behavioral health specialist evaluation was identified, direct provider-to-provider communication, particularly regarding information on previous work ups and/or treatments, would be possible. The patient would be seen in a timely fashion, with acknowledgement of the assessment already performed by the primary care physician and, on completion of the behavioral assessment, the behavioral health provider would contact the primary care physician with recommendations. When appropriate, a jointly developed treatment plan process could be utilized. In addition, patients should have access to culturally competent providers and appropriate translation services.

Recommendations:

To address these obstacles and realize the vision for improved communication, the Workgroup developed the following recommendations and suggests a two-year implementation timeline:

A. Enhance mutual understanding of the respective roles of both primary care physicians and behavioral health providers.
B. Conduct a needs assessment of behavioral health services in Rhode Island to identify unmet needs and appropriately target resources.
C. Adapt the behavioral health infrastructure to ensure timely, open communication between primary care physicians and behavioral health providers.
D. Improve basic information exchange between providers.
E. Support intentional physician-to-physician communication.
F. Increase behavioral health access for underserved patient populations.
G. Strengthen state infrastructure to facilitate improved communication.
H. Advocate for insurance coverage changes.
I. Develop benchmarks and identify best practices.

Conclusion:

Primary care physicians play a significant role in the delivery of behavioral health interventions. As a result, it is essential that direct communication between primary care physicians and behavioral health providers be promoted to effectively address patients' needs in a timely manner. Implementation of the recommended strategies and actions over time can help to enhance behavioral health capacity, communication, and referral systems and assure improved access to high quality primary care and behavioral health services.

Acknowledgements

Under the exemplary leadership of Donya Powers, MD, Chair of the Primary Care Physician Advisory Committee (PCPAC) from June 2000 – June 2002, the following individuals generously contributed their expertise and time to the PCPAC Mental Health Workgroup. Their efforts to promote improved coordination of primary care and behavioral health services on behalf of all Rhode Islanders are greatly appreciated.

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Rhode Island Department of Health
Primary Care Physician Advisory Committee (PCPAC)

Report of the PCPAC Mental Health Workgroup

Purpose:

Over the last three years, PCPAC has been discussing the crisis in behavioral health in Rhode Island. To address the critical issues, a workgroup was formed comprised of PCPAC members and others with expertise in the behavioral health field. The PCPAC Mental Health Workgroup met for two sessions in 2001 (March 21 and April 11) and for four sessions in 2002 (January 23, February 13, March 13 and April 10) to shape a plan in response to the following focus question: *In an effort to ensure more timely, appropriate service to all patients (adults and children) who need behavioral health treatment, how can provider-to-provider communication be improved?*

The Workgroup acknowledged that there are major access, infrastructure, and financing issues impacting the current behavioral health crisis. While focusing on communication, the workgroup discussed the major issues extensively. The discussions are reflected in this report. In addition, the Allied Advocacy Group for Collaborative Care addressed the issues in depth. Their work can be seen in the report entitled *Putting It All Together: Rhode Island's Hope for Building a Health Care System (Some Assembly Required).*

Process:

The 2002 Workgroup established meeting protocols to guide the work, maintain focus and ensure maximum productivity. Using the 2001 meeting summaries as a springboard, the Workgroup addressed a series of process questions posed by the facilitator to guide interactive analysis and planning. The agenda for each meeting focused sequentially on developing the separate sections of the plan: 1) Baseline Facts; 2) Practical Vision; 3) Barriers; and 4) Strategies and Actions.

Participants:

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Scope of the Problem:

Rhode Island is facing a crisis in the delivery of behavioral health services. There is a critical shortage of providers, particularly child psychiatrists. Extrapolating from national data, between 25,000 - 50,000 Rhode Islanders need some behavioral health intervention annually.[4] Following September 11, 2001, this number can be expected to rise since reports suggest that there will be a significant increase in post-traumatic stress disorders with a corresponding increased demand for behavioral health services. In addition, the recent closure of outpatient services at Butler Hospital, the only private, nonprofit adult, adolescent and child psychiatric and substance abuse hospital in Rhode Island, has intensified the already severe shortage of available psychiatrists.

Nationally and in Rhode Island, primary care physicians provide a substantial proportion of the behavioral health interventions.[5] Data indicate that up to 90% of psychotropic medications are prescribed in the primary care setting.[6] Since primary care physicians have difficulty receiving reimbursement for providing behavioral health services, their contributions go largely unrecognized if claims data are studied. When referral to a behavioral health specialist is needed, access and communication barriers are common. However, in order to successfully address patients' needs, it is imperative that primary care physicians be able to communicate with behavioral health providers in a timely fashion. Specific examples of difficulties cited by workgroup members include: 1) barriers created by behavioral health benefits managers; 2) lack of current and accurate lists of participating providers accepting new patients; and 3) lack of routine communication with consultants due to perceived confidentiality concerns and time constraints.

For a complete list of key baseline points generated by the Workgroup, see Appendix A.

Practical Vision for Improved Communication:

The Workgroup developed a vision of ideal communication between primary care and behavioral health providers. It should be noted that, for the purpose of this report, a two-year timeline was utilized. The Workgroup envisioned an environment where consultation with the appropriate behavioral health specialist functioned much as any other specialist referral. Telephone consultation and "curbsiding" would be available. Primary care providers would not feel obligated to practice beyond their "comfort zone" due to difficulties in accessing appropriate behavioral health providers for their patients. Once the need for a behavioral health specialist evaluation was identified, there would be the option of direct provider-to-provider communication about the consultation question as well as information exchange on any previous work up and/or treatment. The patient would be seen in a timely fashion, with acknowledgement of the

[4] Into the Millenium --> Recovery (RI Mental Health Plan, June, 1999)
[5] National pharmacy data
[6] Rhode Island pharmacy data

assessment already performed by the primary care physician. After the behavioral assessment, the behavioral health provider would contact the primary care physician with recommendations. When appropriate, a jointly developed treatment plan process could be utilized. Ideally, providers ultimately would be co-located in a collaborative practice. In addition, patients would have access to culturally competent providers and appropriate translation services.

For a complete list of the key points the Workgroup generated for the Practical Vision, see Appendix B.

Barriers:

Workgroup members identified a number of major barriers to achieving the practical vision. Shifts in patient needs are surpassing the current provider capacity. Traditionally inadequate reimbursement rates have limited the recruitment of some behavioral health specialists, especially in child psychiatry. Among providers and staff, a lack of cultural competency and the limited availability of translation services are problematic. The referral process is typically circuitous and coupled with administrative inefficiencies/duplication of effort results in some patient's needs getting lost in the referral process. Communication gaps between providers, especially as regards medication management, pose another hurdle along with the bifurcated conceptual framework (a mind/body dualism) for patient care. Providers feel a sense of being restricted by behavioral health benefits management and there is an overall lack of Rhode Island specific data in key areas.

For a complete list of the key points the Workgroup generated for the Barriers, see Appendix C.

Action Recommendations:

To address these obstacles and realize the vision for improved communication, the Workgroup recommends the following:

A. Enhance mutual understanding of the respective roles of primary care physicians and behavioral health providers.
B. Conduct a needs assessment of behavioral health services in Rhode Island.
C. Adapt the behavioral health infrastructure to ensure timely, open communication between primary care physicians and behavioral health providers.
D. Improve basic information exchange between providers.
E. Support intentional physician-to-physician communication.
F. Increase behavioral health access for underserved patient populations.
G. Strengthen state infrastructure to facilitate improved communication.
H. Advocate for insurance coverage changes.
I. Develop benchmarks and identify best practices.

Strategy A: Enhance Mutual Understanding Between Primary Care Physicians and Behavioral Health Providers.

***Actions**:*

- Assist primary care physicians to better understand the current practice of psychiatry and the structure of the behavioral health system.
- Support regionally based, cross-disciplinary training opportunities for primary care physicians and behavioral health providers to help build a common understanding and a common language.
- Within the health care community, identify and support clearly delineated roles for behavioral health providers at all levels of practice along with appropriate roles for primary care physicians and staff. Communicate appropriate roles/responsibilities to providers in each discipline and inform patients of the interdisciplinary team model of care.

Strategy B: Conduct a Needs Assessment of Behavioral Health Services in Rhode Island.

Strategy C: Adapt the Behavioral Health Infrastructure to Ensure Timely, Open Communication Between Primary Care Physicians and Behavioral Health Providers.

Actions:

- Co-locate behavioral health care clinician(s) in primary care physician sites/offices and vice versa.
- Develop effective/efficient protocols to communicate "pertinent positives" that facilitate triage and provider-to-provider communication.
- Develop a referral system/communication model to assure that primary care physicians can *directly* request a psychiatrist consult at mental health organizations and eliminate indirect communication mechanisms that rely on utilizing intermediate mental health workers.
- Establish and fund a "telephone consult" program to allow primary care physicians access to a child psychiatrist on a daily scheduled basis.
- Establish a fast track "medication clinic" at mental health facilities.
- Develop an "*Ask the Expert*" information resource via telephone and/or e-mail for primary care physicians to obtain relevant information on appropriate medications; management of patients presenting with specific symptoms, etc.
- Identify county-based behavioral health providers who will commit to providing easy access to primary care physician consultation by phone/at office.

Strategy D: Improve Basic Information Exchange Between Providers.

Actions:

- Establish mutually agreed upon baseline data for use by primary care physicians making referrals to community mental health clinics.
- Develop a standardized reporting form for behavioral health providers to complete and return to the primary care physician.

- Develop “best practice” referral and communication forms to facilitate the primary care physician’s ability to refer to behavioral health providers (including information such as past medical history, reason for referral, ancillary studies requested, etc.).
- Develop a behavioral health provider directory that accurately reflects accessibility, specialty (e.g. child psychiatry) and insurance participation.
- Challenge the differences in accessibility of specialty care between mental health centers/social services agencies and traditional private practices.
- Ensure Health Insurance Portability and Accountability Act (HIPAA) compliance.

Strategy E: Support Intentional Physician-to-Physician Communication.

Actions:

- Advocate for reimbursement of a telephone consult code (between primary care physician and mental health provider) as well as face to face care conferences.
- Advocate for insurance reimbursement of a case manager to coordinate the relationship between the primary care physician and the behavioral health provider.
- Schedule planned phone consult times between the primary care physician and staff psychiatrist to address medical issues that might follow the patient’s behavioral health treatment.
- Develop incentives, formal and otherwise, for primary care physicians and behavioral health clinicians to communicate.

Strategy F: Increase Behavioral Health Access for Underserved Patient Populations.

Actions:

- Develop continuing medical education for primary care physicians who provide behavioral health services for their patients.
- Utilize J-1 Visa/Conrad 20 slots to attract linguistically appropriate providers (both primary and behavioral health) in underserved areas.
- Increase the availability of translation services for non-English speaking patients.
- Establish financial incentives to attract child psychiatrists and minority clinicians to Rhode Island.
- Develop and fund cultural competency education for all providers.
- Develop financial incentives to recruit Brown Medical students into psychiatry and to encourage psychiatry residents to remain in Rhode Island on completion of their training.

Strategy G: Strengthen State Infrastructure to Facilitate Improved Communication.

Actions:

- Foster arrangements on the state level that promote better communication between primary care and behavioral health (e.g. finance, treatment, prevention, promotion, research).
- Emphasize parity of behavioral health with all health as part of a holistic approach to patient care.

- Require the behavioral health system to keep the primary care system informed in its sphere of work.
- Foster collaboration between state agencies to coordinate activities and maximize each agency's strengths to fill the gaps that exist in serving patients.

Strategy H: Advocate for Insurance Coverage Changes.

Actions:

- Document and disseminate information that accurately describes the volume of behavioral health services now being provided by primary care physicians in Rhode Island.
- Advocate for primary care physician reimbursement of mental health codes.
- Require managed care plans to have an adequate cadre of mental health providers and behavioral health services, consistent with Chapter 23 guidelines.
- Create an advisory committee to assist in determining such adequacy.
- Urge insurance companies to credential programs (accredit) rather than individual clinicians.

Strategy I: Develop Benchmarks and Identify Best Practices.

Actions:

- Examine different models of collaboration between primary care and behavioral health that exist in Rhode Island and nationally.
- Study outcome data as they become available and develop "best practice" recommendations.
- Encourage (financially and otherwise) the development of pilot programs to explore ways to achieve improved communication and service delivery among primary care and behavioral health providers.

APPENDIX A

Key Points Generated at the Meetings to Describe the Scope of the Problem

The Workgroup recommends the addition of data describing Rhode Island's demographics, insurance status, common medical and behavioral health diagnoses, and the variety of public and private systems serving Rhode Island's behavioral health needs to this section.

Scope of the Problem:

- Rhode Island is facing a crisis in the delivery of mental health services.
- Extrapolating from national data, between 25,000 - 50,000 individuals annually in Rhode Island need some mental health intervention; primary care physicians provide a significant proportion of this intervention.
- Up to 90% of psychotropic medications are prescribed in the primary care setting, implying that a significant proportion of mental health services are delivered in this setting. However, the contribution of primary care physicians often is unrecognized.
- Only one in three individuals in the general population receive needed behavioral health treatment.
- Inadequate compensation contributes to the extensive under-documentation of depression, etc. because current insurance coding procedures do not accurately reflect the services provided by physicians.
- Reimbursement for psychiatrists in Rhode Island ranks at the lowest tier in New England. Regardless of the provider, behavioral health services, especially services for children, are under-compensated.
- There are no Rhode Island specific data on these issues.
- Reports since September 11, 2001 suggest that a significant increase in post-traumatic stress disorders with a corresponding increased demand for mental health services can be expected.

Community Support Programs (RI Department of Mental Health, Retardation, and Hospitals - MHRH):

- Regulations require a primary care contact by all community support program (CSP) individuals per year. In addition, communication between the VA and community mental health providers is required.
- Public sector regulations apply only to the 5500 adult community support patients. Audits are conducted to verify that a primary care contact (a physical exam/any visit) has occurred, but communication/feedback is not a requirement, and no audit is conducted for children.
- 10 co-occurring medical disorders account for 90% of the morbidity and mortality in the MHRH patient population.
- At any one time, 9,000 individuals are eligible for the MHRH mandated provision while only approximately 6,000 are actually treated within the community mental health centers.
- The vast majority of seriously mentally ill individuals who are amenable to treatment receive care (through nursing homes, hospitals, the Rhode Island Department of Corrections, etc.).

Specific Communication and Access Issues:

- The Providence Center has implemented a system for sending data from a child's psychiatric evaluation or twice-yearly psychiatric summary to the child's primary care physician (with consent); information on medication changes is not included.
- With the patient's signed consent, community mental health centers send documentation to primary care physicians via a form that includes an evaluation section.
- Private mental health providers are not required to send evaluation documentation to primary care physicians.
- The access number given by managed care providers to privately insured patients who need mental health treatment virtually factors out communication with the patient's primary care physician.
- Modify/expand provider network listings to include appropriate practice information since many psychiatrists on the list provide in-patient care only and are not available to the general population.

APPENDIX B

Key Points Generated at the Meetings to Describe the Practical Vision for Improved Communication

The Workgroup decided to focus its vision based on a two-year timeline to assure that available resources could be allocated appropriately.

Two years from now, the PCPAC Mental Health Subgroup hopes to see:

1. An effective, high-quality communication infrastructure
2. Open, collaborative professional style and operational structures
3. Knowledge exchange that promotes high quality patient service
4. Strong, aligned communication among state agencies
5. Shared guidelines and standards among providers
6. A health care system oriented toward patient service

1. An Effective, High Quality Communication Infrastructure

- Communication with mental health providers occurring by phone or some other accepted means to enable primary care physicians to initiate appropriate treatment.
- Use of technology to support communication.
- Network lists that reflect providers who are actively practicing and accepting patient referrals.
- A telephone and/or email “hot line” that enables primary care physicians to access requisite information quickly.
- A central clearinghouse of provider vacancies and strategies for effectively negotiating the managed health care system.
- Capacity for asynchronous electronic communication - “e-visits” to address difficulty of direct, person-to-person communication.

2. Open, Collaborative Professional Style and Operational Structures

- Primary care providers no longer serve as default providers.
- Teams comprised of a mental health professional, primary care provider, psychiatrist, clinical nurse specialist, social worker, and family member collaborating and communicating to ensure needed patient service.
- Collaboration between the primary care physician and co-located behavioral health provider with access to psychiatric backup.
- Rich, inclusive partnerships among various providers.
- Open access: increased reciprocity/behavioral health acceptance of referral from primary care physicians and improved communication between primary care and behavioral health front-line screeners.
- Providers able to make referrals more directly without the “run-around”.
- Incentives for strong communication between primary care physicians and behavioral health providers and within the behavioral health community.

3. Knowledge Exchange That Promotes High Quality Patient Service

- All parties informed of co-occurring illnesses and behaviors that affect prognoses, informed of treatment plans, and regular communication of these conditions with patients.
- All providers knowledgeable about the 10 co-occurring medical disorders that complicate the care of CSP patients.
- Phone consult service for primary care physicians, e.g. "*Ask the Expert*".
- Clear understanding of what constitutes "urgency" and "high risk".
- Improved understanding of primary care physician regarding the mental health system and its processes.
- Timely access by primary care physicians to requisite information, especially medications; direct communication beyond voice mail.
- Child care and school staff included in the communication and ultimately the management and support of the work.

4. Strong, Aligned Communication Among State Agencies

- Improved communication on the state level among the Rhode Island Departments of Children, Youth and Families (DCYF), Education (RIDE), Human Services (DHS), Health (HEALTH), and Mental Health, Retardation, and Hospitals (MHRH).
- Enhance state agency communication by designating a lead agency to facilitate the process.
- Collaborate with the Rhode Island Children's Cabinet to assure stronger and better-aligned interagency communication.

5. Shared Guidelines and Standards Among Providers

- Shared practice guidelines for common behavioral health disorders that would include components for primary care physicians and behavioral health providers.
- Clear standards/guidelines of expectations for communication between primary care physicians and child and adult psychiatrists that would be promulgated to the medical community (e.g. *initial evaluations and summary of care will be exchanged).*
- Clear understanding of CSP definition to facilitate referral to direct care, not the waiting list.
- Communication strategies and actions that are consistent with current regulations.

6. A Health Care System Oriented Toward Patient Service

- Aspects of the current system modified to allow for more direct service of patients with acute needs, elimination of complicated, circuitous referral process.
- Behavioral health providers are linguistically appropriate for the population/sites/ communities they serve.
- Review by MHRH of regulations that impede care and acknowledgement/commitment to make appropriate regulatory changes.
- Appropriate and equitable reimbursement of primary care physicians to facilitate management of behavioral health conditions.
- A single standardized format that enables authorization/review of services across all insurers.
- Control by managed health benefits management corporations lessened.

APPENDIX C

Key Points Generated at the Meetings Describing Barriers to the Vision for Improved Communication

The barriers and challenges that obstruct the practical vision include:

1. Shifts in patient needs that surpass the current provider capacity
2. Lack of cultural competency
3. Complicated, circuitous referral process
4. Administrative inefficiencies
5. Communication gap regarding medication management
6. Bifurcated conceptual framework for patient care
7. Sense of being restricted by managed care system
8. Lack of Rhode Island specific data

1. Shifts in Patient Needs That Surpass the Current Provider Capacity

- Shortage of child psychiatrists in Rhode Island who are accepting new patients
- Increasingly younger patients with substance and alcohol abuse
- Dysfunctional family systems increase the complexity of patient needs
- Patient mobility/multiple placements result in fragmented counseling and treatment, as with children in foster care
- Significant number of untreated mothers (especially in need of treatment for post-partum depression) who are non-English speaking and/or < 18 years of age
- No protection for the uninsured
- Limited provider time

2. Lack of Cultural Competency

- Insufficient, affordable, competently trained language interpreters for mental health
- Language barriers hamper communication, especially with patients from community health centers

3. Complicated, Circuitous Referral Process

- Direct referrals by primary care physicians to a child psychiatrist are not always possible: patients are assessed by an intake person, then by a therapist and many never see a child psychiatrist.
- Referral process does not facilitate clinician-to-clinician communication.

4. Administrative Inefficiencies

- Lack of available long-term placement options creates patient backlog.
- Behavioral health screening process often duplicates work that has been done by primary care physicians.
- No formal screening tool exists for primary care physicians to assess patient needs for mental health services.
- Long administrative delays prevent crisis intervention in a timely fashion.

5. Communication Gap Re: Medication Management

- Little consultation between behavioral health provider and primary care physician regarding medication management.
- Information about medications not regularly exchanged between primary care providers and mental health providers.
- Potential issue of information overload/logistics if data on medication changes are communicated between primary care physicians and behavioral health providers.

6. Bifurcated Conceptual Framework for Patient Care

- Primary care and behavioral health are viewed as two separate universes.

7. Sense of Being Restricted by Managed Care System

- Insurers do not reimburse primary care physicians for case conferences with behavioral health providers (and non-parity reimbursement).
- Primary care providers have difficulty being reimbursed for the provision of behavioral health services.
- Primary care physicians find referral and communication with private mental health centers difficult.
- Laws and regulations are not being fully utilized, such as CSP entitlement and parity for provision of certain services.
- Difficulty of finding accurate, current contact numbers for each provider (primary care physicians and behavioral health providers).
- So called “networks of providers” that are just names on a list.

8. Lack of Rhode Island Specific Data